Transfer of Assets
Section 1115 Research & Demonstration Waiver Proposal

State of New Hampshire
Department of Health and Human Services

CONTENTS

Section 1
Executive Summary and Introduction

This Demonstration Project comes as a result of Legislative action and is proposed primarily to discourage individuals from making large transfers of assets for less than fair market value in order to qualify for Medicaid payment of future medical services. This proposal is based on the belief that it is reasonable and fair to expect individuals who have adequate resources to use their own assets to pay for medical care. The Medicaid Program was established to pay medical costs for the needy; not to pay medical costs for individuals who have artificially and intentionally impoverished themselves in order to qualify for Medicaid services. The proposal is designed to better fulfill the original objectives of the Medicaid Program and embraces policy contained at Chapter 175 of the 2005 Laws of New Hampshire effective 6/30/05 (also known as "HB 691"). It further reflects recommendations made by the National Governor's Association (NGA) in its June 15, 2005 report on Medicaid Reform appended hereto. Several of these concepts are contained in the newly published Congressional Budget Office Medicaid Commission report.

It is anticipated that the changes proposed for this Demonstration Project will lead to a significant reduction in estate planning, which shifts the costs of medical care to the state and federal governments, and ultimately the taxpayers. Even though certain changes proposed here may not result in immediate, significant savings, the changes are part of a comprehensive package designed to reduce opportunities for artificial impoverishment (thereby resulting in significant savings over the long term and enhanced program integrity), and to achieve a change in societal attitude from one of Medicaid entitlement for long-term care (LTC) costs to Medicaid as a safety net for the indigent. As the NGA noted on page 2 of its report, "What is clear is that Medicaid can no longer be the financing mechanism for the nation's long term care costs . . ."

Section 1917(c)(1) of the Social Security Act requires states to deny coverage of certain LTC services to otherwise eligible institutionalized individuals who transfer assets for less than fair market value (FMV) within a 36-month look-back period, or 60-month look-back period in the case of transfers to irrevocable trusts. The penalty period begins on the first day of the month in which the transfer occurs, regardless of the need for LTC assistance or the individual's living arrangement and often results in the penalty period expiring prior to the individual actually requiring LTC services.

Although the federal transfer of asset (TOA) policy was intended to treat all individuals equitably, advance planning significantly nullifies its intended purpose. The current federal TOA policy has resulted in widespread use of estate planning to intentionally shift assets to third parties, allowing the transferors to qualify for the Medicaid payment of LTC services and avoiding estate recoveries for both the state and federal governments. Estate planning literally diverts millions of dollars that could be used to pay for LTC services and discourages individuals from seeking and purchasing LTC insurance, or employing other methods to meet their needs for a continued quality of life. These tactics have impeded Medicaid in fulfilling its intended role as payer of last resort. The NGA took note of this trend in its report as well at page 4:

There is concern that many individuals are utilizing Medicaid estate planners in order to shelter assets and therefore qualify for Medicaid funded long term care services. Examples of such estate planning approaches include:

- Sheltering assets in trusts, annuities and other financial instruments that are then deemed as "not available to the Medicaid beneficiary;"
- Converting "countable assets" under the law into "exempt assets"; and
- Transferring assets through joint bank accounts or other means to close relatives.

In 2003, the NH Legislature took a step toward addressing the impact of current federal TOA policy when it enacted NH RSA 167:4 IV (a), which states that the laws of NH are in need of amendment to "assure that otherwise ineligible individuals are prevented from artificially impoverishing themselves to receive benefits to which they are not otherwise entitled and to facilitate recovery of improperly obtained benefits and to assure the fiscal integrity of the funds appropriated for Medicaid." Additionally, Chapter 319, Section 177 of the 2003 Laws of New Hampshire requires that the Commissioner of the Department of Health and Human Services (Department) seek a waiver of federal law for the purpose of increasing the "look-back" period from 3 to 5 years for determining eligibility for Medicaid assistance. The changes contemplated by the Legislature as reflected in the aforementioned laws would compel individuals to utilize non-Medicaid resources for their LTC needs. The basic premise for seeking these changes is that individuals capable of funding a share of their cost of nursing home services should be discouraged from intentionally shifting this fiscal responsibility to the Medicaid Program.

In furtherance of this effort and in compliance with Chapter 319, Section 177 of the 2003 Laws of New Hampshire and Chapter 175 of the 2005 Laws of New Hampshire (HB 691), the State proposes to increase the look-back period to 60 months for all transfers of assets made for less than FMV with the intent to become eligible for Medicaid nursing home services; change the date upon which a penalty period is imposed for individuals who transfer assets for less than FMV with the intent to qualify for Medicaid nursing home services; and encourage the purchase of LTC insurance by exempting individuals possessed of conforming policies from the resource threshold and estate recoveries dollar-for-dollar.

The NGA, citing President Bush's proposed budget, supports such initiatives, stating on page 4 of its report:

> The President's budget proposes to change the rules regarding penalties for individuals who transfer assets in order to become eligible for Medicaid long term care. The proposal would begin that penalty period on the date that the individual enters the nursing home or becomes eligible for Medicaid, whichever is later.
>
> This approach should be encouraged and a number of other similar approaches should be explored around assets transfers to prevent estate planners from simply moving to alternate schemes. Other approaches to address inappropriate transfers could include:
>
> • Increasing the look-back period from three years to five years (or longer);
>
> • Limiting the amount and types of funds that can be sheltered in an annuity, trust or promissory note

And again, the NGA at page 12 lends support for LTC insurance incentives, or 'partnership' programs:

> Four states (California, Connecticut, Indiana, and New York) have been operating promising partnerships between Medicaid and the long-term care insurance industry. Although their approaches differ, the basic concept is that individuals who purchase private insurance and exhaust its coverage would be allowed to access Medicaid and still protect some of their assets. There are two basic approaches that the four states utilize—the dollar-for-dollar model and the total asset protection model. In the dollar-for-dollar model, beneficiaries are able to keep personal assets equal to the benefits paid by the private policy. In the total asset model, all assets are protected after a threshold for years of coverage has been crossed, typically three or four years. In both cases, Medicaid becomes the payer when the partnership policy benefits are exhausted. States are projected to realize savings because Medicaid becomes the payer of last resort, not the first.
>
> Federal law prohibits the expansion of these partnerships beyond those four states, but 17 states have passed enabling legislation allowing them to begin such a program should the federal prohibition be repealed, and several others are currently exploring that option. While long-term care partnerships do not promise a silver bullet for Medicaid's long-term care crisis, they can be a key part of the solution, and therefore all states should be allowed to participate.

Through its passage of HB 691, the State is also moving toward other reforms of Medicaid not subject to waiver, but which are demonstrative of the State's desire to contain costs without compromising care for indigent people of failing health. These efforts also highlight the State's many faceted approach to Medicaid reform and illustrate that the State views this waiver as part of a broad initiative, not as the panacea reform. For example, HB 691 provides for a shift from nursing facility restrictive environments in favor of expanded opportunities for home and community based care that is yet another concept embraced by the non-partisan NGA, which notes at page 12 of it's report:". . . reforms should give states more tools to encourage home and community-based care . . ."

Assuming it was demonstrated that the applicant had transferred assets for less than fair market value for the purpose of becoming eligible for Medicaid, the State has in place hardship provisions as is required by federal law for relief from ineligibility penalties under certain circumstances at He-W 620.01 (t). Current policy permits the agency to waive the penalty period for transfers of assets for less than FMV when the agency determines that denial of eligibility for institutional level of care would result in undue hardship under certain defined conditions. In no event shall an applicant who verifies their transfer was made for purposes other than qualifying for Medicaid be penalized.

The proposed initiatives would be a test of new transfer rules to see if they are more effective than current federal law in preventing the burden of medical care from shifting from asset-rich individuals to the state and federal governments. Through this proposed Demonstration Project, the behavioral changes of applicants would be evaluated with the expectation that the revised TOA policy would encourage personal responsibility and the use of LTC insurance, while also realizing substantial savings to the Medicaid Program. Nursing facilities should also benefit as this Demonstration Project will increase the duration and number of privately-paid periods. If successful, the new rules could become a national model for other states and provide guidance to Congress for enacting new laws that protect the integrity of the Medicaid Program. Finally, this Demonstration Project would provide the Centers for Medicaid and Medicare Services (CMS)

with the empirical evidence needed to re-evaluate the TOA rules under the State Medicaid Plan and effectuate the necessary policy changes to discourage estate planning to circumvent these rules.

The State requests a waiver of Section 1902(a)(18) [requiring compliance with Section 1917] to the extent necessary to implement its proposals as well as a waiver of Section 1902(a)(17) [requiring comparability between coverage groups].

Section 2
Demonstration Design

A. Introduction to Demonstration Design

The Legislated purpose of this proposed Demonstration Project is to discourage individuals from making large transfers of assets for less than fair market value for the purpose of qualifying for Medicaid payment of their medical services in the future. Since the implementation of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), the State has observed numerous tactics employed by estate planners to encourage and enable their clients to divest themselves of their assets so that they might qualify for Medicaid sooner than they would have if they had not divested themselves of their assets. These observations were shared with House Energy Commerce Committee in May 2005 in response to a survey distributed to all States.

This proposal is based on the belief that it is reasonable and fair to expect individuals who have adequate resources to use their own assets to pay for their medical care. Although there are already a number of statutory provisions aimed at preventing the improper transfer of assets for less than fair market value to qualify for coverage under Medicaid, the State takes the position through its passage of HB 691 that there are strong public policy arguments for enhancing the limits on such transfers. Clearly the non-partisan NGA supports such changes as well.

Limited public dollars are available for Medicaid coverage for an ever-increasing number of individuals who are requesting those dollars. It is of utmost importance for these limited public resources to be used to assist only those individuals who truly cannot afford to provide for their own medical care. This observation has been codified by the NH Legislature in HB 691, "The general court recognizes that the demand upon the Medicaid system will increase sharply in the near future due to the rapid aging of the population and the increasing numbers of citizens 85 years of age and older." In contrast, those individuals who have sufficient assets should be expected to pay for their own care. The State's proposal would target those who have voluntarily transferred their assets for less than fair market value in order to qualify for Medicaid, but would still protect individuals who truly need Medicaid to pay for their medical care.

The federal law regarding TOA is designed to deter individuals from divesting themselves of their assets in order to qualify for Medicaid, and to penalize those who do divest themselves of their assets for less than FMV. However, as the law is currently designed, the law does not provide adequate deterrence and contains several loopholes. As has been observed by many states and cited in the NGA report, sophisticated estate planners who help individuals with substantial assets to fully or partially avoid a penalty period by transferring those assets to a third party for less than FMV exploit these loopholes. Such estate planning not only results in individuals becoming eligible for Medicaid benefits prematurely but, also protects those individuals' assets from recovery. The divestment shifts the cost of care from individuals with the ability to pay to the state and federal governments, and ultimately the taxpayers.

In addition, this shift takes money that should be devoted to those who cannot afford to pay for their medical care and directs it towards those who can afford to pay for their medical care. Instead of being a program to pay for the medical care of those in need, as envisioned by the Medicaid Act (Section 1901 of the Social Security Act), Medicaid becomes a program that also pays for the medical care of those who can afford to pay for it themselves, but who voluntarily and intentionally impoverish themselves so that the state and federal governments pay for their care instead. Since the source of public funds is limited, those who can afford to pay for their own care, but voluntarily impoverish themselves effectively take money from the needy, leaving the Medicaid Program with insufficient funding to provide for their health care needs. Thus, this proposal is designed to better fulfill the original objectives of the Medicaid Act.

This proposal will help prevent individuals with the ability to pay for nursing home care from receiving Medicaid assistance, while avoiding any increase in the burden on individuals in need. Although entirely eliminating estate planning aimed at qualifying for medical assistance is impossible, the State believes that the changes proposed for this Demonstration Project will lead to a significant reduction in both the success and the quantity of this type of estate planning that currently saps health care dollars from state and federal governments.

Should the demonstration be effective, it can serve as a model for other states and provide guidance to Congress for enacting new legislation that will effectively preserve health care funding so that it can be more effectively targeted to those truly in need.

B. Components of the Demonstration Project

This proposed Demonstration Project is comprised of the following components:

- 60-Month Look-Back. Increase the "look-back" period to 60 months for transfers of assets to an individual for less than fair market value with the intent it qualify for Medicaid nursing home services, as contemplated at Chapter 319, Section 177, 2003 Laws of New Hampshire and Chapter 175, 2005 Laws of New Hampshire (HB 691).
- Penalty Period Beginning. The asset transfer penalty period would begin when an individual applies for Medicaid nursing home services and is determined to be otherwise eligible, or when the agency becomes aware of the transfer, whichever occurs later. The transfer penalty for recipients would begin when the agency becomes aware of the transfer or following an existing penalty period, whichever is later as contemplated in HB 691.
- LTC Insurance Incentive. Encourages purchase of conforming LTC insurance policies by exempting such individuals from resource limit and estate recovery, dollar-for-dollar, should they require Medicaid for LTC costs after exhausting their policy, as contemplated by HB 691.

C. Specific Waiver Components

I. Increase the "look-back" period to 60 months for transfers of assets to individuals.

- **Current Provision:** The look-back period for asset transfers is 36 months prior to the month of application for Medicaid for all transfers except for transfers into irrevocable trusts.
- **Proposed Waiver:** Extend the look-back period for all transfers of assets for less than fair market value to 60 months prior to the month of application.
- **Rationale:** The 36-month look-back period allows asset-rich individuals to give away substantial assets prior to the look-back period. It is anticipated that extending the look-back period, coupled with changing the date when the transfer penalty period actually begins, will discourage individuals from transferring large amounts of assets for less than FMV.
- **Effective Date.** Pursuant to HB 691, effective for transfers made after 3/15/05 and after Federal approval of this Demonstration Project, approval from the State Fiscal Committee and effective passage of the necessary state laws and/or rules. The waiver will not apply to transfers made earlier than 3/14/05.

II. The transfer penalty period for applicants would begin when an individual applies for Medicaid and is determined to be otherwise eligible, or when the agency becomes aware of the transfer, whichever is later. The transfer penalty period for recipients would begin when the agency becomes aware of the transfer or following an existing penalty period, whichever is later.

- **Current Provision:** Under Section 1917(c) of the Act, the penalty period imposed for a transfer of assets for less than FMV begins in the month of the transfer.
- **Proposed Waiver:** The transfer penalty period for applicants would begin the month an individual applies for Medicaid and is found otherwise eligible, or when the agency becomes aware of the transfer, whichever is later. The transfer penalty period for recipients would begin at the beginning of the month the agency becomes aware of the transfer or following a period of ineligibility existing when the transfer was made.
- **Rationale:** This proposed change closes the loophole typically used by Medicaid estate planners, which allows a person to give away assets for less than FMV, calculate the number of months of penalty, and then keep only that much more in assets to pay for care during the penalty period. Removing this loophole makes it more likely that estate planning will be done for purposes other than receiving Medicaid.
- **Effective Date** Pursuant to HB 691, effective for transfers made after 3/15/05 and after Federal approval of this Demonstration Project, approval from the State Fiscal Committee and effective passage of the necessary state laws and/or rules. The waiver will not apply to transfers made earlier than 3/14/05.

III. Encourage the purchase of conforming long term care insurance policies (at a minimum 36 months of nursing home payment at the average private pay rate for county nursing facilities with an annual benefit inflation factor of at least 5% and coverage for home and community based care equivalent) by exempting applicants possessed of such policies from the resource threshold and estate recoveries dollar-for-dollar.

- **Current Provision:** Only a few states, which had waivers, submitted prior to OBRA 1993 are permitted to provide this incentive.
- **Proposed Waiver:** Allow NH to join the ranks of states described at Section 1917(b)(1)(C) that had a waiver for this purpose prior to May 14, 1993.
- **Rationale:** Encouraging the purchase of policies which cover more than the estimated average nursing facility stay at a market rate will increase the number of individuals who can privately pay for their long term care. Those individuals who require LTC beyond the 36 months of insurance coverage could obtain Medicaid without the typical 'spenddown' of excess resources and with protection against estate recoveries equal to the value of the policy they purchased, the dollar-for-dollar method. This concept strikes a balance with the previously discussed concepts, which seek to increase the disincentives for creative Medicaid planning by offering a more responsible and legal alternative consistent with the original intent of the program.
- **Effective Date:** Effective for applications made 180 days from the date of Federal approval of this Demonstration Project.

D. Due Process and Undue Hardship Protections

The following existing due process guarantees and hardship protections will continue to apply under the demonstration.

I. **Substantive Due Process.** Pursuant to State Administrative Rule, He-W 620.01 (t)(2), no penalty will be assessed where an individual demonstrates the transfer was made for purposes other than becoming eligible for Medicaid. Acceptable reasons, which may be used to prove the fact that the transfer was *not* made for purposes of qualifying for assistance, include, but are not limited to, assets transferred:

- To prevent foreclosure or sale of the asset by the lien holder, thus preventing total loss of the asset;
- To meet the terms of an oral or written agreement which would be recognized as a legal contract in a court of law, including debts arising from such agreement; **or**
- For self support because the individual's income and resources were insufficient to meet basic needs or maintain upkeep of the property, and the individual's basic needs were provided for in return for the transfer, or the individual lived off the proceeds of the asset; **and,**
- In the case of failing to cause assets to be received, the individual is not able to afford to take the necessary action to obtain the asset, or the cost of obtaining the asset is greater than the asset is worth.

II. **Procedural Due Process.** All applicants and recipients are afforded procedural due process regarding Department actions. Written notices of decision inform individuals of the action taken, reason for the action, and policy/authority for the action. All notices of negative actions (e.g. denials, terminations or reductions in benefits) are accompanied by directions for requesting a fair hearing before the Department's Administrative Appeals

Unit (AAU). The AAU is an administratively attached but independent arbiter of disputes between Department clients and the Department.

III. **Undue Hardship.** Pursuant to He-W 620.01 (x) and (y)[1] and Section 1917(c)(2)(D) of the Act, a transfer of asset penalty is not imposed if the penalty would result in an undue hardship to the transferor under the following conditions:

1. The asset was transferred by an agent or authorized representative and it can be demonstrated and documented that the individual lacked the mental capacity to comprehend the disqualifying nature of the act and
   a. A written and signed statement by a licensed physician states that the individual was mentally incapacitated at the time of the transfer; or,
   b. An order of findings from a probate court concerning the individual's competency is provided to the district office;
2. *Application of the penalty would deprive the individual of necessary care such that his health or his life would be endangered.*

The hardship language sited above is supported by the Governor, the legislature, and the department and will become part of House Bill 690 (2005).

[1] The italicized language is not yet part of the administrative rules or the Medicaid State Plan, but as indicated above, all of the language cited is expected to be incorporated into House Bill 690 (2005). The department intends to amend the New Hampshire Medicaid State Plan to incorporate all of the above language.

Section 3
Organization And Administration

A. Organizational Structure

The New Hampshire Department of Health and Human Services is the state agency with responsibility for administering medical assistance to approximately 92,000 individuals under Titles XIX and XXI of the Social Security Act. Within the Department, primary responsibility for the Medicaid Program is divided between the Division of Family Assistance (DFA) and the Division of Medicaid. The former is responsible for determining eligibility and setting policy for Medicaid and all other programs of financial assistance as well as food stamps and subsidized child care. The Division of Medicaid administers payment of claims for services provided to recipients of Medicaid, determines disability, sets payment rates and develops policy for these areas. Medicaid is administered at the state level, though 12 district offices are in the community for receiving applications, conducting interviews and conducting direct service to the client population.

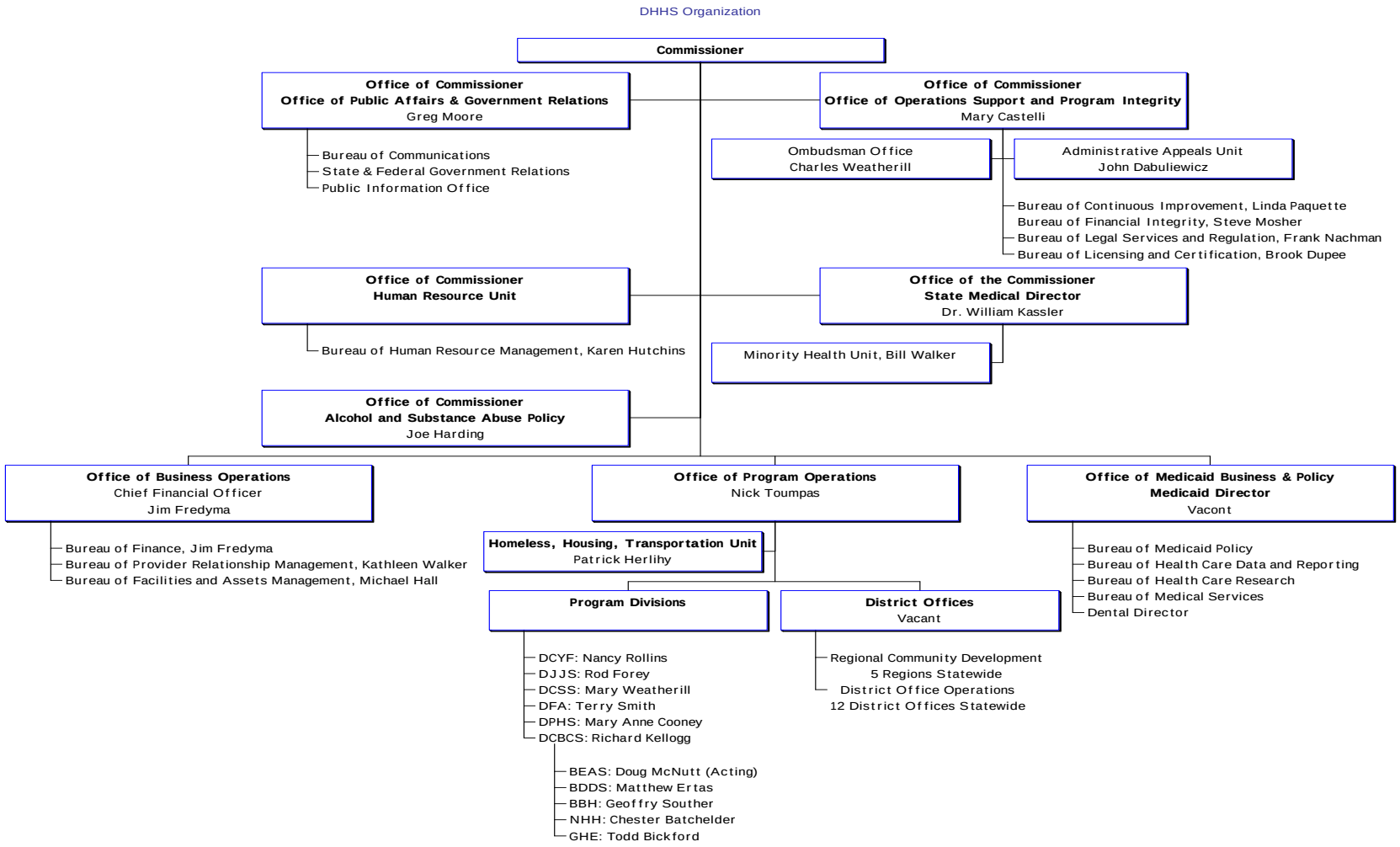
B. Key Personnel

John A. Stephen – Commissioner
Richard Kellogg – Acting State Medicaid Director
Terry R. Smith – Director of Division of Family Assistance
Julia Kaplan – Division of Family Assistance Policy Administrator
Joyce Gleason – Medicaid Eligibility and State Supplemental Program Specialist
Lisabritt Solsky – Manager of the Administrative Rules Unit and Counsel to Division of Family Assistance and Contact Person for this Waiver

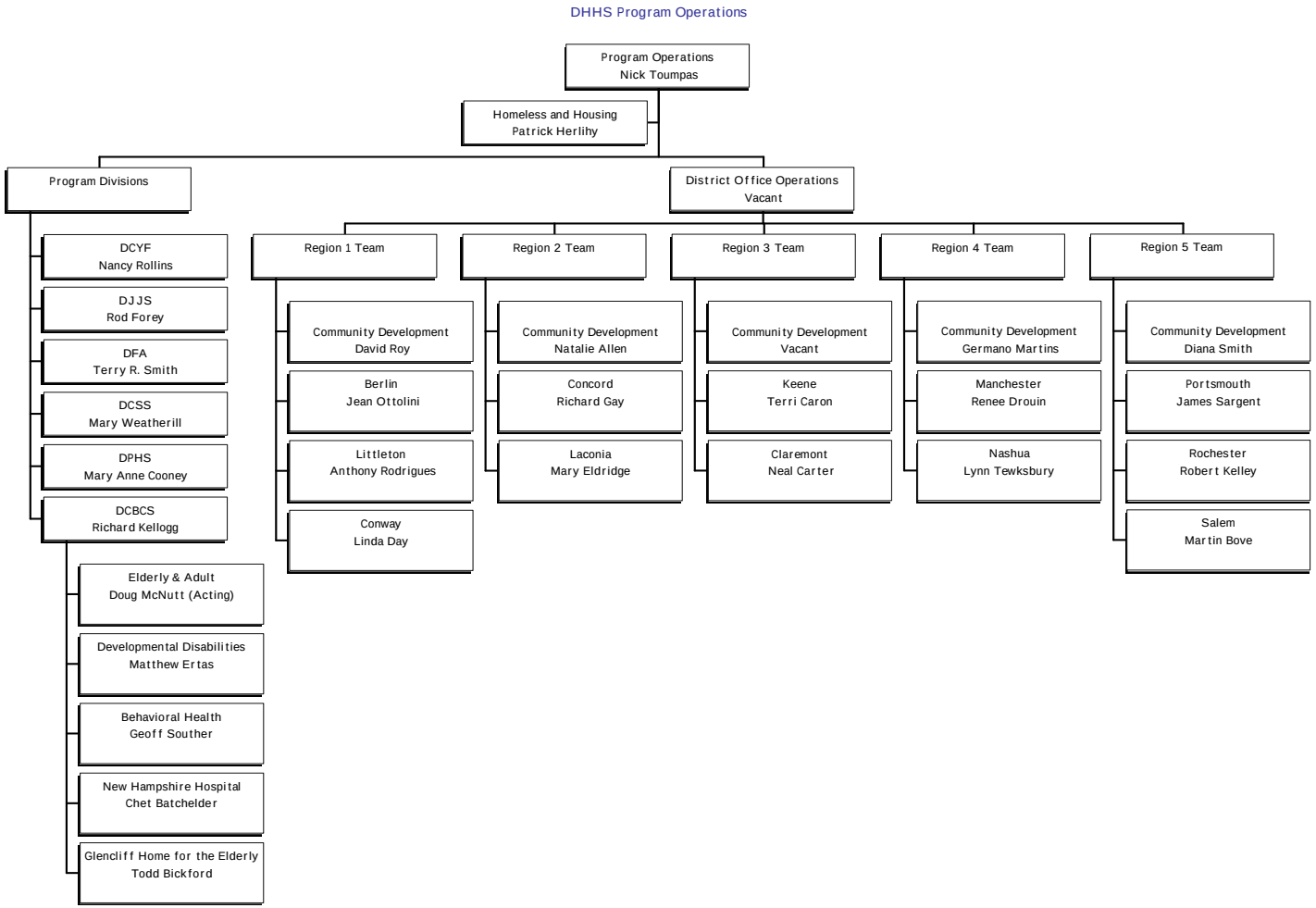
C. Functional Responsibilities

The DFA, Policy Development Unit, in conjunction with the Administrative Rules Unit, will develop policy necessary to implement the waivers. The policy unit and the Medicaid Eligibility Program Specialist will work with the DFA Training Unit to train trainers who will conduct live remote training over the Internet with the 12 district offices staff. Applicants or recipients aggrieved by the waiver policies will have the Department's administrative appeals process available to them for fair hearing of grievances. Additionally, the individuals listed above will meet periodically to review data on transfers and the impact of the Demonstration Project.

DHHS Organization Structure



DHHS Program Operations



Section 4
Evaluation

A. Demonstration Objective

The Legislated objectives of this Demonstration Project are to discourage large transfers of wealth for the purposes of qualifying for Medicaid payment of all Medicaid services, and to encourage personal responsibility for payment of the cost of LTC services. This section presents a plan to analyze the impact of increasing the look-back period to 60 months for transfers of assets for less than FMV to individuals; changing the date when a penalty period is imposed for individuals who transfer assets for less than FMV in order to qualify for Medicaid assistance; and creating a LTC insurance "partnership" with future potential Medicaid applicants.

It is anticipated that the changes proposed for this Demonstration Project will lead to a significant reduction in estate planning designed to shift the costs of Medicaid supported medical care from individuals with an ability to pay for those services to the state and federal governments, and ultimately the taxpayers. Even though certain changes proposed here may not result in immediate, significant savings, the changes are part of a comprehensive package designed to reduce opportunities for artificial impoverishment thereby resulting in significant savings over the long term.

B. Suggested Research Hypotheses for the Demonstration

The principal research hypotheses are:

1. The design of the Demonstration would cause a shift in the spenddown behavior of Demonstration participants.
2. The change in the TOA policy would encourage personal responsibility for the cost of nursing home care.
3. The Demonstration would be cost-effective to the state and federal governments.
4. The Demonstration would guide the development of state and federal health care policy by including program changes to Medicaid.

C. Suggested Data Sources for the Evaluation

Several data sources could be used to test the research hypotheses:

1. **Eligibility and Enrollment Data**
   Eligibility and enrollment data could be analyzed to determine whether stricter TOA policies have an impact on: a) the number of Medicaid eligibles; b) the average length of stay paid by Medicaid; and, c) overall nursing facility admissions and lengths of stay.

2. **Medicaid Management Information System (MMIS) Data**
   A review of the frequency and amount of improper asset transfers for less than fair market value made both before and after implementation of the Demonstration Project could be analyzed to determine whether there is a shift in the behavior of Demonstration participants. Additionally, Medicaid LTC expenditures both before and after implementation of the Demonstration Project could be analyzed to determine the value of savings (through cost avoidance) to Medicaid.

D. Suggested Plan for Data Analysis

Using the data described above, the State could focus its analysis on the following questions:

1. How does a change in penalty structure under the TOA rules and extending the look-back periods for transfers of assets for less than FMV for applicants/recipients of Medicaid LTC services, affect the likelihood that the numbers of penalties being imposed would decrease?
2. How does a change in the penalty structure affect the likelihood that persons who would otherwise transfer assets pay privately for their care prior to applying for Medicaid?
3. How do the proposed changes reflected in the Demonstration Project realize savings (through cost avoidance) for the Medicaid Program?

Section 5
Costs and Caseloads

A. Introduction

Section 1115 Demonstration waivers must not cost the federal government more than administering the program without the demonstration. In this context keeping costs fixed or even cost avoidance (savings) are considered budget neutrality. The process of establishing budget neutrality required certain assumptions about current practices, based on anecdotal evidence from the State's Medicaid eligibility specialist and counsel to the division that determines Medicaid eligibility. No data exists quantifying certain behaviors that this waiver seeks to limit. That being said, the provisions of this waiver are but one element of a comprehensive plan to return Medicaid to its original purpose as the payor of last resort and of providing medical insurance to the truly needy. While the initiatives contained in the waiver concepts may only directly impact some individuals, these changes will be inspirational to countless others who might have contemplated these financial maneuvers and will now avoid them. Further, these waivers will serve as part of the State's overall strategy to achieve a cultural change in people's attitude about Medicaid from one of entitlement to a safety net program for the indigent. As of September 2004, there were 96,621 Medicaid recipients in New Hampshire, of them, 27,481 are adults.

B. Cost Savings

1. 60-Month Look-Back.
    a. Extension from 36 months to 60 months for transfers of assets to individuals for less than fair market value.
    b. Projected cost savings based on analysis of New Hampshire Medicaid application records detailed in the Caseload portion of Section 5 revealing 58 nursing facility (NF) applicants who had made transfers for less than FMV within the current look-back period.
    c. As noted in the Table-Initiative 1, there are no cost savings to just the increase in the look-back though coupled with initiative 2 below, however a longer look-back yields more applications for review with potential transfers for less than fair market value.
2. Penalty Period Beginning.
    a. The asset transfer penalty period would begin when an individual applies for Medicaid and is determined to be otherwise eligible, or when the agency becomes aware of the transfer, whichever occurs later. The transfer penalty for recipients would begin when the agency becomes aware of the transfer or following an existing penalty period, whichever is later.
    b. Incremental savings anticipated from penalties applied to transfers that would be within the expired penalty period under current practice.

c. Projected cost savings based on the average cost per Medicaid recipient for NF services and the number of applications per year for transfers that were below FMV.
d. Cost savings are detailed in the Table-Initiative 2.

3. Long Term Care Insurance Incentive
   a. Exempt applicants and recipients with conforming LTC insurance policies from the resource threshold and from estate recoveries dollar-for-dollar to the value of the policy.
   b. Fiscal impact is indeterminable due to the impossibility of projecting market penetration as a result of this provision. Even if this concept visits no change on market penetration, the State will achieve budget neutrality as required of an 1115 Demonstration. However, it is expected that the incentive here, balanced with concepts 1 and 2 above, will increase market penetration of conforming policies resulting in reduction in spending that will exceed any offset as a result of estate recovery exemption for qualifying individuals. A conforming policy must cover at a minimum 36 months of nursing facility care, approximately 6 months more than the average nursing facility length of stay.

Initiative Number	Initiative Description	Incremental Initiative Savings	Year 1: SFY 2006	Year 2: SFY 2007	Year 3: SFY 2008	Year 4: SFY 2009	Year 5: SFY 2010
1	Look-back Extended	Penalties applied to transferred assets from 36 to 60 months.	$0	$0	$0	$0	$0
2	Beginning of Penalty Period	Penalties applied based on the Medicaid application date or when the agency becomes aware of the transfer, whichever is later.	957,420	1,914,840	1,914,840	1,914,840	1,914,840

Notes:

1) Cost Savings provided in this Demonstration Waiver are Budget Neutral as contemplated by Section 1115 of the act to New Hampshire's future Medicaid Expenditures.

2) Cost Savings for each Initiative listed above are inter-dependent.

3) Cost Savings for Initiative 2 include savings from Initiative 1

4) Based on 81 NF apps per years transferring the average $47,665 for an average 8 Mos. penalty

The statewide average monthly NF cost of $2955 X 8 = $23,640 savings per app.

$23,640 X 81 = $1,914,840 in savings

Based on projected Implementation Date for Initiatives of January 1, 2006

C. Caseloads

1. Analysis of these concepts commenced following passage of Chapter 319, Section 177 of the 2003 Laws of New Hampshire, at which time it was estimated by the Bureau of Adult and Elderly Services (BEAS) that there would be approximately 3,055 applications for NF services in calendar year 2004. These numbers formed the basis of the projections herein as well as fiscal analysis done in support of HB 691. Actual data for calendar year 2004, which was not previously available, reveals that there were 3231 nursing facility applications. Because the actual number of cases is slightly higher than anticipated, it is reasonable to conclude that the savings would also be slightly higher than projected
2. The average NF monthly cost per member is $3,000.
3. The average statewide private NF rate – the penalty divisor - is $6,004.25 per month.
5. There were 118 individuals who applied for NF services between 11/01/2002 and 10/31/2003 who transferred assets below fair market value with the intent to be Medicaid eligible within the current 36/60-month look-back period. Of these 118 cases, the Medicaid eligibility program specialist personally reviewed 39 of the NF cases. Her findings in the review of these 39 cases are assumed to be representative of the general trend within the total 118 cases and form the basis of the following calculations.

Based on the review:

For NF Applicants:

- 49% (58 individuals) of the NF transfers were for less than FMV.
- The penalty period had expired prior to the month of application for 74% (43 individuals) of the applicants that had transferred assets for less than FMV.
- The average amount transferred for individuals whose transfer period had expired was $47,665.
- The average transfer penalty for individuals whose penalty period had expired was 7.94 months.
- The penalty period was still ongoing at the time of application for 26% (15 individuals) of the applicants who had transferred assets for less than FMV.
- The average amount transferred for individuals whose transfer period was still ongoing at the time of application was $11,405.
- The average transfer penalty for individuals whose penalty period was still ongoing at the time of application was 1.9 months.

- Although we have no hard data to verify this assumption, using anecdotal data, it is assumed that extending the look-back period will double the number of individuals with impermissible transfers of assets for the initial 5-year waiver period. Once the initial five years of the waiver is over, there should be a significant reduction in the number of transfers for less than FMV as it is anticipated that the waiver will act as a disincentive for individuals to transfer their assets for less than FMV in order to qualify for Medicaid.

Section 6
Waivers Requested

A. Section 1902(a)(18) requires the State agency to comply with Section 1917 of the Act. All the waivers contemplated herein depend on waiving Section 1902(a)(18) and Section 1902(a)(17), as set out more specifically below.

1. Waive application of Section 1917(c)(1)(B) to allow the agency to look-back 60 months for basic transfers of assets to individuals for less than fair market value.

2. Waive application of Section 1917(c)(1)(D) to permit the agency to commence application of the transfer penalty on the date of application or the first date the applicant would otherwise be eligible, whichever is later. For recipients, the transfer penalty will commence when the agency becomes aware of the penalty or after an existing penalty, whichever is later.

3. Waive Section 1917 (b)(1)(C)(ii) to afford NH the status of states that submitted conforming waivers prior to May 14, 1993 exempting individuals with LTC insurance coverage from estate recovery dollar-for-dollar. Waive Section 1902(a)(17) insofar as it requires comparability in treatment of eligibility groups. The incentive to purchase LTC insurance shall only apply to applicants for Medicaid funded long term care services, not to other eligibility groups. Additionally, waiving Section 1902(a)(17) will permit the application of the other waiver provisions to only applicants for nursing home services and not to individuals defined at Section 1902(a)(10)(A)(ii)(VI).